ASSESSMENT OF THE UPTAKE OF HIV TESTING AND COUNSELING SERVICES (CASE OF MINORS) IN MUTARE DISTRICT, ZIMBABWE

BY

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ABSTRACT

This study assessed the uptake of HIV testing and counseling services basing on the case of minors in Mutare district, Zimbabwe. In order to carry out the study, a sample of 70 participants (44 children, 16 parents/guardians and 10 key informants) were selected using convenience sampling. The researcher used questionnaires and interviews as tools for data collection. The main purpose of the study was to examine barriers to access of HIV testing and counseling, among the minors. Some of the findings were presented in the form of tables, graphs and pie charts. The study revealed the barriers affecting the uptake of HIV testing and counseling services. The findings of the research revealed the social barriers like fear and stigma and discrimination which have prevailed for a long time in HIV and AIDS issues as the main barriers. While people are aware of how HIV is transmitted and the benefits that getting tested for HIV has on children they under utilize the facilities due to fear and the stigma and discrimination associated with HIV and AIDS. This study recommends that Ministry of education, sport and culture should strengthen the education of HIV and AIDS in schools. AIDS service organizations should offer continuous education in schools, churches and communities so as to increase the uptake of HIV and AIDS testing and counseling among the minors. Furthermore, there is need to strengthen the referral system for those parents who come for HIV testing so that if they have children they also bring them for testing. Finally, it is recommended that counseling and advice should be provided to parents/guardians on how they should inform their children of their HIV positive status and at what age. Lastly, the researcher recommends that a further research be undertaken in order to establish the existence of stigma and discrimination in the communities.

DECLARATION

This dissertation is my original work except where sources have been acknowledged. The work has never been submitted, nor will it ever be, to another University in the awarding of a degree**.**

Student……..Date……..

Supervisor…….Date……..

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Once again thank you all and to God be the Glory!

DEDICATION

This research is dedicated to all my family members.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CDC	Centre for Disease Control
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
HIV	Human Immuno Virus
IRIN	Integrated Regional Information Networks
NGOs	Non Governmental Organisations
OI	Opportunistic Infection
PMTCT	Prevention of Mother To Child Transmission
UNAIDS	United Nations AIDS Organisation
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

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CHAPTER 1 BACKGROUND AND INTRODUCTION

1.0 THE PROBLEM AND ITS SETTING

1.1 Introduction

The study seeks to assess the uptake of HIV testing and counseling services in Mutare urban district Zimbabwe. Chapter one, highlights on the background information to the study, the statement of the problem, the purpose of the study, objectives guiding the study, research questions, assumptions, significance of the study, limitations, delimitations and definitions of terms.

1.2 Background

HIV and AIDS is causing a lot of problems in Zimbabwe that ranges from social problems to economic problems. The first case of HIV infection was identified in 1985 and then the problem of HIV and AIDS has continued to grow at an alarming rate ever since. (*National HIV and AIDS Policy*, (1999). In response to the epidemic, a National HIV and AIDS policy was developed in 1999. Among other issues, the policy also spells out that providing care and counseling is essential in order to minimise the personal and social impact of HIV and AIDS. The policy states that under informed consent to HIV testing and counseling that until legal age of consent, a child is considered a minor and consent is obtained from parents or legal guardian. This implies that children cannot seek for HIV counseling and testing services without their parental

or guardian's consent. HIV is associated with stigma and discrimination and some people do not want to get tested. This is due to fear and if they are afraid of knowing their status they cannot take their children for such tests. Due to AIDS related deaths which are being recorded in the country there are children who are being left orphaned hence the increase in the number of orphans and child headed families. These orphans will be taken care of by their relatives and family friends who might also fail to understand the importance for HIV testing and counseling.

The HIV prevalence in children was stated to be at 3.16 (2. 78-3.68) in 2012. The Annual AIDS Deaths between the age group of 0 – 14 was 13,378 in 2010, 11,446 and in 2011 it was 9,326. An estimated, 1400 people die of AIDS every week and about 99 3220 children aged 17 years and below have lost one or both parents to AIDS. (Zimbabwe HIV and AIDS Estimates , 2009). This report shows that nearly (10%) 107 388 people living with HIV in Zimbabwe were children below the age of 14 years and about 35 190 children are in urgent need of ART. Of these, only less than half, about 16 000 were receiving ART by end of August 2009. (HIV Estimate report: 2009).

Children and infants need to have access to HIV testing and counseling services to facilitate early diagnosis of HIV infection and minimise morbidity and mortality. Access to HIV testing impacts treatment, care and prevention and can result in further desirable

effects such as improved health outcomes for children and their families improve. (WHO and UNICEF, 2010).

Some children are living in child headed families and there is no one to consent for them. Failure to access HIV Testing and Counseling services is a major challenge since Zimbabwe has also joined the Global aim of creating an enabling environment for Universal access to HIV and AIDS services and HTC is said to be the entry point. The need for children to get tested for HIV comes from the background that children are also vulnerable due to the following factors:

- Some children are born from the HIV infected mothers who transmit the virus to them before or during birth.
- Other children are sexually active.
- During home based care some children get cross infections.
- Child sexual abuse is on the rise and some perpetrators are HIV positive.
- If the parents or guardians of these children fail to consent for these children this might mean they might succumb to HIV before legal majority age or they might keep on spreading the virus unknowingly.

WHO recommends that provider initiated HIV testing and counselling for infants and children is implemented to facilitate diagnosis and assure linkages and access to HIV related services. (UNAIDS and UNICEF, 2004).

1.3 Research problem statement

Minors are not allowed to access HIV counselling and testing services without their parents or guardians' consent. According to the Mutare Urban 2012 estimates there are 123 055 children under the age of 15years which leads to 53% of the population. From the statistics collected by the National AIDS council a total of 1385 under 15 years children were tested during the period of January to December 2012. For someone to access the HIV treatment, care and support services there is need for one to know his or her HIV status, that is through getting tested for the HIV virus. Zimbabwe is experiencing a low uptake of pediatric drugs since the start of the ART roll out programme in 2004 despite the availability of the drugs for children. Mid Term Review Report of the Republic of Zimbabwe Government HIV and AIDS Strategic Plan (2006-2010) the country was at (10%) ten percent uptake as of July 2009. This has raised concerns among stakeholders on the possible impact that HIV could be having on children. In his message to mark World AIDS Day on December 1, 2009, the President of the Republic of Zimbabwe Comrade R.G. Mugabe bemoaned the slow uptake of anti-retroviral drugs among children despite the availability of child formulas (Herald December 28 2009). It is surprising that while the drugs are even expiring, they are not accessible to many children who need them. Therefore, it is the main thrust of this study to investigate the barriers to the uptake of HIV testing and counseling services by the minors.

1.4 Purpose of the study

This study's main purpose is to examine barriers to access of HIV testing and counselling, among the minors.

1.5 Significance of the study

The study aims at identifying the barriers to HTC services for minors. The study will help to come up with recommendations that can then be in cooperated into the policies that will increase access to HIV/AIDS services for minors in Zimbabwe. The introduction of prevention from the mother to child transmission was recently introduced hence most of the children who were born to HIV+ mothers before the PMTCT were highly at risk. HIV testing and counselling is the main entry point for an individual to access prevention methods so as to remain negative and to treatment, care and support for those who are infected.

1.6 Research objectives

- To assess the accessibility of HTC services by children under the age of 16.
- To investigate the willingness of parents and guardians to take their children for HTC services.
- To assess the knowledge, attitude and practices of the under 16 to HTC services.

- To establish the strategies to scale up HTC among the minors.

1.7 Research questions

- How many minors are accessing HIV testing and counselling in Mutare?
- Do parents and guardians take their children for HTC?
- Are the minors able to accept and manage their HIV status on their own?
- What are the knowledge, attitude and practices of the under 16 to HTC services?

1.8 Delimitation of the study

This study will only focus on examining on the uptake of HIV testing and counselling only for the minors in Mutare. The study will not get deeper on other factors which leads to access to HIV and AIDS services.

1.9 Operational Definitions of Terms

HIV is the Human Immuno virus which is responsible for causing AIDS. AIDS is the Acquired Immuno Deficiency Syndrome which is characterized by signs and symptoms of severe immune deficiency, weight loss of more than 10% body weight, diarrhea lasting more than one month, and fever lasting more than one month (Castilla: 2005).

Acquired Immune Deficiency Syndrome (AIDS), "is a means by which the body loses the ability to fight against infection because the immune system is weakened by HIV" (Jackson, 2002).

Antiretroviral (ARV) Ray, Woelk and Jackson, (2002) defines **Antiretroviral** as "a substance, drug or process that destroys a retrovirus or inhibits its replication."

Asymptomatic is defined by Ray et al (2002) as "a stage of a disease during which a person shows no outward signs or symptoms of a disease"

Prophylaxis are "measures designed to preserve health and prevent the spread of disease" Ibid.

Paediatrics is the branch of medicine that deals with ailments suffered by infants, children and teenagers between the ages of 0 to 15 years.

Attitudes according to Myers (1986) are "beliefs and feelings that may predispose us to respond in particular ways to objects people and events".

Serostatus is **"**the condition of having or not having detectable antibodies to a microbe in the blood as a result of infection. One may have either a positive or negative serostatus".

Immunology is both the study of the human immune system and the field of medicine that treats diseases of the immune system

Minor is a child who is under the age of 16 years.

HIV testing is his is a process of making an individual to know whether there is HIV virus in his or her body.

1.12 Summary

This Chapter has looked at the background to the study, statement of the problem, significance of the study, purpose of the study, the objectives, assumptions of the study, limitations, delimitations, and operational definitions of terms. The next chapter looks at literature review.

CHAPTER 2 LITERATURE REVIEW

2.0 Introduction

Chapter two highlights on the barriers affecting uptake of HIV testing and counselling among the minors. The knowledge, beliefs and attitudes of people towards HIV testing and treatment for children that affect the uptake of HIV testing and counselling services with reference to different research studies that were carried out in different settings previously. Overally, literature review is about the views of some authorities on the subject which assists the researcher to be focused. In this chapter, the point of view on the uptake of HIV testing and counselling was expressed following different intellectuals. A literature review is essential in formulating questions that need further research.

2.1Theoretical Framework

The research study was guided by the symbolic interactionism theory. According to this theory, people inhabit a world that is in large part socially constructed. The people give meaning of objects, events and behaviours that come from the interpretation people give and they vary from one group to another. As Giddens (2004) posits, symbolic interactionists are interested in the ways people interpret the social world and the meanings ascribed to it. This approach applies to the realm of health and illness in order to understand how people experience being ill or perceive the illness of others. This may include how the individual's identity is affected by living with a chronic illness. In this

case, HIV and AIDS is mostly associated with prostitution, an act which the society label as deviant, to the church it is associated with evil doers or a sign of an unclean person whereby one would have acted against God's will. Socially constructed as it is, an individual is forced to act basing on the meanings ascribed to it. In an effort to try to avoid the labels and the stigma associated with the condition, guardians or parents may avoid testing for themselves and later on for their children, making children to suffer the consequences. Linked with Goffman's dramaturgy theory, an individual finds ways in which to survive by withdrawing into the performing self. The guardians or female parents may start pretending as if everything is alright. They may go for the HIV tests with their children but would not return for the results or they may get the results but would not access the treatment for the child as a result of the stigma associated with the condition which is fueled by the interactions in societies.

2.2 Children and HIV

According to the United Nation (UN) convention on the rights of the child (1990), a child is defined as any individual below the age of 18years. According to the demographic health survey of 2006-2011, 43% of the population is under 15 years of age. The HIV prevalence in children was at 3.16 (2. 78-3. 68) in 2012. The Annual AIDS Deaths a month the children ages between 0 – 14 years was 13,378 in 2010and in 2011 they were 9,326. An estimated, 1400 people die of AIDS every week and about

993 220 children aged 17 years and below have lost one or both parents to AIDS (HIV Estimate report: 2009).

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2007, the high rate of HIV infection in children is the result of the following factors:

Burden of HIV infection in women -21% of women of reproductive age are HIV+.

- Rate of mother to child transmission of HIV in 2004 was estimated that a total of new infections occurred among children below the age of 15years with mother to child transmission accounting up to 90% of these childhood infections.

  In the same vein, according to Ouagadougou: 2009, health authorities estimate that less than 25% of HIV infected children in Burkina Faso who required treatment were taking life-long-saving drugs while thousands of children at risk were undiagnosed because their families refuse to have them tested. It was propounded that while 75% of the families grant permission for their children to be tested at the hospital, authorization is given reluctantly. It took time because families refuse, and only accept to test when their children fall ill a second time. It was during the second hospitalization that they could accept.

More than 1,000 children are newly infected with HIV every day, and of these more than half will die as a result of AIDS because of a lack of access to HIV treatment. In addition, millions more children every year are indirectly affected by the epidemic as a

result of the death and suffering caused in their families and communities. Preventing HIV infection, providing life prolonging treatment and relieving the impact of HIV and AIDS for children and their families and communities is possible. However, a lack of necessary investment and resources for adequate testing, antiretroviral drugs, and prevention programmes, as well as stigma and discrimination, mean children continue to suffer the consequences of the epidemic World Health Organisation, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund "WHO/UNAIDS/UNICEF: 2011).

Although national prevention strategies are being implemented, older children continue to be infected through horizontal transmission such as child sexual abuse and early sexual debut. Responding to questions from participants during debate to map the way forward on universal access to treatment in December 2009, the WHO official in Zimbabwe, Dr Chakanyuka said parents and guardians were not taking their children for testing. She reconfirmed that this had seen many children dying of the disease although the country had enough child ART formulas.

The factors such as religious beliefs, stigma and discrimination, financial constrain, cultural beliefs, attitudes and lack of knowledge can overshadow the medical factors. Children between the ages of 6 months to 15 years who are eligible for paediatric ART therefore remain a grey area, though improvements are being realized rapidly.

In his message to mark World AIDS Day on December 1 2009, the President of the Republic of Zimbabwe Comrade R.G. Mugabe bemoaned the slow uptake of anti-retroviral drugs among children despite the availability of child formulas .There had been studies among adults in developing countries and among youths in industrialized countries UNAIDS (2001) and Weinhartdt and Carey, (2001), example for the above reference; (UNAIDS, 2001) taken together from these sources suggests that VCT may be an appropriate and effective strategy for young people. Studies among adults in developing countries report behaviour change after VCT on a range of indicators including condom use, reduction in number of partners and reduction in STI incidence.

There are more than 16 million children under the age of 18 who have lost one or both parents to AIDS. Most children living with HIV/AIDS– almost 9 in 10 – live in, the region of the world where AIDS has taken its greatest toll. Lyons (2001) discusses several psychological effects of HIV and AIDS on children. She notes that children can easily lose their rights to live as children especially when they are orphaned. At the end of 2010, there were 3.4 million children living with HIV around the world. (WHO, 2011).

In developing countries overall it is estimated that 6 percent of boys and 11 percent of girls have had sex by age 15 UNICEF/UNAIDS (2010). Children are also at risk of becoming infected with HIV through sexual abuse and rape. In some parts of Africa, the

myth that HIV can be cured through sex with a virgin has led to rapes, sometimes of very young children by infected men - although whether or not this is a significant factor in child sexual abuse in the region is disputed (Epstein & Jewkes (2009). According to World vision (1999) HIV and AIDS increase in the number of orphans in Zimbabwe where about 10% of children are being abused. The abuse and increase from the erosion of the support structures as a result of parents being weakened by or dying of AIDS. There is also stigma and discrimination of children irrespective of whether they are infected or affected.

Sexual transmission does not account for a high proportion of child infections but in some countries children are sexually active at an early age. This is potentially conducive to the sexual spread of HIV among children, especially in areas where condom use is low and HIV prevalence is high. In sub-Saharan Africa 16 percent of young females (aged 15-19) and 12 percent of young males reported having sex before they were 15 in 2007. In Lesotho, these figures are 16 percent and 30 percent, respectively; in Kenya, 15 percent and 31 percent. Identifying and testing the HIV exposed infant as early as possible is crucial as diagnosis of HIV allows timely access to life saving care including Antiretroviral therapy for those who are infected (WHO, 2009).

2.3 HIV and AIDS Policy

A policy is a rule of action intended to provide relative stability, consistency, uniformity and continuity in the functioning of an institution. Pfiffner (1999:308). Policy provides a comprehensive framework for action and is thus goal oriented. HIV and AIDS is causing a lot of problems in Zimbabwe which ranges from social problems to economic problems. The first case of HIV was identified in 1985 and since then the problem of HIV and AIDS has continued to grow at an alarming rate (National HIV and AIDS Policy, (1999). In response to the epidemic a National HIV and AIDS policy was developed in 1999. Among other issues the policy also spells out that providing care and counselling is essential in order to minimise the personal and social impact of HIV and AIDS. The policy states that under informed consent to HIV testing and counselling that until legal age of consent, a child is considered a minor and consent is obtained from parents or legal guardian.

Though the HIV pandemic is devastating to the world, it is possible to manage the HIV epidemic. Based on results from the Genscreen test, HIV prevalence declined in 15- 49-year-old pregnant women from 32 to 24% over the period 2000–04. Based on the combined test algorithm, HIV prevalence declined from 26% in 2002 to 18% in 2006. HIV prevalence fell in consecutive surveys in all age groups up to age 40 years (UNAIDS, 2005). The country's national estimate for HIV prevalence amongst adults stands at about 13.7 % down from 26% around 1999 (Zimbabwe National HIV and

AIDS Estimates 2007). Zimbabwe is one of the few countries in the world currently experiencing a general decline in HIV prevalence, hopefully it continues to fall. Despite the good sign of decline the double digit prevalence is still unacceptably high; therefore, much still needs to be done. The high literacy rate, remarkable behaviour change of the nation and will power of the leadership and the donor community will one day result in an HIV free. (Duri K et al, 2013). One form of management is through the use of counselling. Moyo et al. (2002) stated that counselling is a powerful tool in the HIV/AIDS education, prevention, and care processes. Sangiwa (2000) states that voluntary counselling and testing (VCT) can elicit sustained behaviour change, prevent mother to child transmission of HIV, and act as a powerful prevention, support, and care mechanism.

According to Southern Africa HIV and AIDS Information Dissemination Service, (SAFAIDS:2007), children and ART remains an extremely important area for overall community preparedness as access to ARVs is being scaled up across Southern Africa However, the barriers to children accessing ART remains, as consent from the child's biological parent or legal guardian must be obtained before HIV testing can be performed except in certain specific circumstances such as expedite testing and when testing is necessary to provide medical care for a life threatening condition (New York State Department of Health 2005). Bekezela Mapanda, the Chairperson of a committee that organized the 2009 World AIDS Commemorations noted that there is need for a review of the policy framework to address issues of HIV and AIDS among children

(Herald December 28 2009). She pointed out that the obstacle to treatment for many children living in Zimbabwe is that they cannot access ARVs on their own as the law requires them to do so in the company of parents and guardians. Thus it is vital to examine and expose the difficulties faced by children with the hope that they will be addressed.

As with other health services many countries require a specific age before they agree to medical procedures such as VCT without parental consent. This legal age of consent is often set an age by which the majority of youths are already sexually active (Boswell and Baggaley 2002, Crowley 2002).

According to Lyons (2003) it is estimated that by 2010, 40million children will lose a parent or both, which means one in every 4-6 children is being orphaned. Thus she further contents, families suffer from the effects of altered roles and relationships the grandparents, especially the grandmothers are then forced to look after these orphans. Lyons also suggest that children are also sexually exploited physical and psychological abused, poor, hungry thus leaving them open to HIV infection.

UNAIDS (1997) points out that with regards to HIV testing, the client should be informed of potential benefits and risks of the test. According to UNAIDS/WHO (2000) informed consent is based on the principle that competent individuals are entitles to

make informed decisions regarding their participation in or acquiescence to, certain events in the context of a professional relationship between health care provider and patient/client.

2.4 HIV stigma and discrimination:

AIDS stigma has been an impediment to the uptake of voluntary counseling and testing (VCT) of HIV. Unless barriers to HIV testing and treatment are addressed children will continue to die in their hundreds of thousands each year. Stigma has accompanied the HIV/AIDS epidemic since its early years (Parker and Aggleton, 2003). As early as 1987, AIDS stigma was identified as one of three distinct epidemics that threatened public health. This stigma has made it difficult to tackle the first two of these epidemics: HIV infection and AIDS (Mann, 1987; Panos Institute, 1990). The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. Stigma is one of the main reasons that HIV positive parents have delayed seeking care for themselves as well as care for their children as it impedes their ability to disclose their HIV status including permitting home visits from community health workers. This hinders in no small way efforts at stemming the epidemic. Since its establishment in 1996, the Joint United Nations Program on HIV and AIDS (UNAIDS) has noted the urgency of dealing with AIDS stigma, stressing it as the most important task in reducing the impact of the HIV/AIDS epidemic (Aggleton, 2001). It complicates decisions about

testing, disclosure of status and ability to negotiate prevention behaviors. Even when testing is locally available, parents may be unwilling to test their babies for fear of stigma and prejudice associated with an HIV positive status. This wide spread fear of stigma is held accountable for the relatively low uptake of prevention of mother to child transmission programmes , a situation which if not dealt with will spill over to mothers not even wanting their babies tested after being infected at birth.

Kiragu, et al, (2007) postulate that HIV related stigma further contributes to avoidance and denial. Denial goes hand in hand with many people continuing to deny that HIV does not exist in their communities. However, no policy or laws can alone combat HIV and AIDS related discrimination. Stigma and discrimination will continue to exist as long as societies have a poor understanding of HIV and AIDS and the pain and suffering caused by the negative attitudes and discrimination practices.

However, with the advent of antiretroviral therapy that conceals or treats visible signs and symptoms associated with AIDS the issue of stigma has improved remarkably. In Zimbabwe discrimination of HIV positive people is prohibited under National HIV and AIDS Policy of 2000 and the Statutory Instrument (SI 202) of 1998 which also prohibits HIV screening for purposes of employment. (Sambisa W et al, 2010).

Jackson (1992) states that clients are afraid of the blame and stigmatisation or isolation and rejection from significant others and the fact that they will increasingly become dependent and unable to cope with the AIDS. SAFAIDS (2002) maintains that HIV is highly stigmatised in many countries wherein infected people experience social rejection and discrimination and are treated as community outcasts. Such discrimination and stigmatization reflects demoralization and dehumanization of other human beings based on misinformation and ignorance.

Once a minor has the capacity to consent, he or she alone has the right to decide whether or not to be tested. An individual under age 18 may not have the capacity to consent and, thus, the right to decide whether to be tested. A medical provider ordering the test must conduct an individualized assessment of every older child's or adolescent's actual ability to understand the nature and consequences of being tested for HIV and to make informed decisions about whether to be tested Information for a Healthy New York (Public Health Law Section 2780.5).

2.5 Prevention of mother to child transmission:

Nine out of ten children infected with HIV were infected through their mother either during pregnancy, labour and delivery or breast feeding, UNAIDS (2010). In a study carried out in Bobo-Dioulasso – Burkina Faso, Sanogo, (2007), indicates that women were reported to be less resistant though than men to having their children get tested.

Often mothers would make their children be tested without letting their families know. Nothing could be further from the truth that fathers resist getting tested or even for their wives to undergo such an exercise, worse still a child whom they know would reveal their status as well.

To prevent mother-to-child transmission (PMTCT) of HIV, antiretroviral drugs are given to the mother before birth and during labour, to the baby following birth and safer infant feeding is also promoted. This approach can almost eliminate the risk of transmission from mother-to-child. Unfortunately, prevention of mother-to -child transmission (PMTCT) services fail to reach most women in resource-poor countries. In 2010 for example, only around half of HIV-infected pregnant women in low- and middle-income countries received drugs to protect their babies from infection. (UNAIDS, 2011).

In the same vein, according to Ouagadougou, (2009) health authorities estimate that less than 25% of HIV infected children in Burkina Faso who required treatment were taking life-long-saving drugs while thousands of children at risk were undiagnosed because their families refuse to have them tested. It was propounded that while 75% of the families grant permission for their children to be tested at the hospital, authorization is given reluctantly. It took time because families refuse, and only accept to test when their

children fall ill a second time. It was during the second hospitalization that they could accept.

Brook and Baker, (1978) says that, “Children are particularly neglected, in everything from prevention, prophylaxis to antiretroviral therapy. He went on to say that "Mother-to-child transmission prevention reaches only 10 percent of pregnant women in Africa at best, he says. He went on to say that follow-up for children with antiretroviral, prophylaxis, or Opportunistic Infection (OI) medicines are a total mess”. It is estimated that more than (90%) of paediatric infections is a result of mother to child transmission (UNAIDS, 2009). Usually, when prevention of mother to child transmission (PMTCT) fails, the cost is enormous in terms of human suffering. Therefore it is of importance to make sure the child is diagnosed for HIV so that the child can get special medical care he or she may need.

While World Health Organization (WHO) targets specify that 10 percent of patients on ART should be children, few programs are meeting this target. deGennaro and Zeitz (2005) pointed out that from a survey of HIV treatment programs conducted by the Global AIDS Alliance, it was found that children make up only (3.6%) percent of all people receiving ART worldwide.

Mutetwa, Chitsike, Ray and Houston (2000, 2001) in (Jackson, 2002) reveal that discussion with a number of Doctors in Zimbabwe reinforces earlier evidence that many do not test for HIV when AIDS is suspected because they can reach only the mothers of the babies with AIDS and they are unwilling to test them without the fathers because of the burden this places on mothers. They will be harassed and blamed for the results and at times isolated and left to look after the child alone.

A 45-year-old widow, infected with HIV by her late husband, told Integrated Regional Information Networks (IRIN) that she was able to get tested only after his husband's death in 2001. The widow's narration as quoted indicates that: "Both he and his family refused that I and my children get tested after I accidentally discovered his ARVs in the house."

2.6 Fear and loss of hope

According to the Kenyan government, many caregivers especially mothers expressed fear that being known to have an HIV-positive child would reveal their own serostatus, exposing them to allegations of promiscuity or unfaithfulness, and forcing them to acknowledge their own health risks. Furthermore, parents may be unwilling to take their child for an HIV test for fear that the child will face prejudice once diagnosed. According to Zoungran (2007) in Burkina Faso, **i**t came to light that "it was not uncommon to see parents leaving the hospital with their children in the middle of the

night to avoid the test". He was quoted as saying, "These adults have not been tested themselves and do not want to know their children's status". From the results of a research carried out by Mhambi (2007) at Hwange Colliary Company the majority of the respondent who had not gone under an HIV and AIDS tests was due to fear of the results being positive and being stigmatized as a result. Two of the respondents 6% viewed an HIV test as something that complicates life.

A family centred approach to HIV testing should be emphasised to maximise all opportunities to identify HIV exposed and infected children. WHO recommendations for HIV testing and counselling state that in all types epidemics, health care providers should recommend HIV testing and counselling as par of the standard care to all infants, children and adolescents who present to health facilities with signs, symptoms or medical conditions that could be indicating HIV infection. (WHO and UNICEF, 2010).

HIV infection affects not only one's physical health but also one's thinking, feelings as well as one's actions. (Ashm publications, 2001) the possible mental health consequences of HIV and AIDS infection are anxiety and depression. With depression the affected person feels negative and helpless about himself /herself, about his/her future and about his surroundings. Jackson (1992) suggests that when a client hears that he/she is HIV positive he may react with shock, denial, anger, anxiety, guilty, weeping, depression and withdrawal. Zulu (2000) suggests that most clients are confused and

helpless or disbelieve the news that they are HIV positive that is go into denial and may think the doctors are wrong.

2.7 Cost:

AIDS treatment for the poor makes sense morally, but it is not feasible technically. Wealth is a major determinant of health in all countries of the Southern Region of the World Health Organization (WHO) and beyond. Social processes often lead to poorer health in less affluent people. This inequality is associated with many avoidable deaths and suffering. Although one of the family's function is to meet the economic needs of its members, to provide care and protection of the young, of females especially in times of pregnancy of the elderly and the sick or disabled (Selfe, 1982). This is not achievable in most developing nations because of the economic situations that prevail. Most of the parents fail to provide for their own children worse for the guardians who are not the children's biological parents. In a study contacted by Kiragu, et al (2007), the costs of seeking healthcare were cited as barriers to accessing pediatric HIV testing and treatment services, especially in Nyanza province.

Even though the cost of providing ARV drugs is theoretically free (covered by government and donor sources), potential clients still have to find money to pay for the high costs of transport, consultation fees, prescription charges and drugs to treat

Opportunistic Infections (OIs). This was quoted from a Person living with HIV and AIDS support group member of Nyanza in Kenya, as saying "*I have a prescription to go and buy drugs for my child but I don't have the money. This child needs medication immediately",* Kiragu, et al (2007). Clients also expressed dissatisfaction with services that claim to meet their needs but actually charge them additional fees for laboratory services or send them elsewhere to buy drugs for OIs.

Families, friends, and the wider community are the first line of protection and support for children, providing for their practical and material needs, as well as social, psychological and emotional needs. Yet in countries with a high HIV prevalence, AIDS places an economic burden on families and communities, making it difficult for them to provide and support for their children. The main reason for this is that AIDS normally affects adults when they are most economically productive. Bongaarts, Heilig, and Pelletier (2009).

2.8 Level of awareness and Knowledge of people towards HIV, testing and treatment

HIV/AIDS education is an important way of reaching young people with knowledge on sexual health and drug abuse. There are many ways to reach young people: including through school, the media, and peer outreach. Whatever the medium, HIV/AIDS

education should not only address the biological facts of HIV and STI transmission and provide information on how to prevent transmission, but it should also take into account the realities of young people's lives - such as peer pressure or gender inequality.

Whenever testing of children is performed the 3 'C' should be observed that's consent, counselling and confidentiality. Parents and guardians also have the right to maintenance of confidentiality and privacy within the context of HIV testing (WHO, 2002). In general, while HIV testing should be encouraged, it should be undertaken once the individual to be tested is both informed of the benefits and risks and voluntarily agrees to it.

The survey data from a research project carried out in Tanzania in 2006 showed that all respondents were aware of the basics of HIV and AIDS, knowledge on how HIV was transmitted the indications for HIV testing was superficial. However with a lack of in-depth information about paediatric HIV, fears and misconceptions still prevail. Many community members believed that once a child has past three years of age, they cannot be HIV positive. With that knowledge gap, only half of the respondents were aware that paediatric Antiretroviral drugs (ARVs) are a lifelong commitment (USAID, CDC and Elizabeth Glaser Paediatric Foundation EGPAF (2006).

Although, 85% of women in Ghana expressed their willingness to be tested, most were concerned about confidentiality and disclosing HIV serostatus because of fear of negative reactions from their husbands, parents, as well as the community at large Ghana Demographic and Health Survey (2008). This implies that many social and cultural barriers confront pregnant women when they decide to opt for HIV testing. Corbett, Dauya, Matambo, Cheung and Makamure (2006) found out that in Mozambique there is limited understanding about factors that determine whether an individual will decide to have HIV test. A lack of knowledge about testing and the fact that HIV can be effectively treated could also lead to poor testing rates. Mothers who have not yet been tested may too be fearful of discovering their child is infected as this would likely mean they are infected also.

Knowledge of HIV transmission, indications for testing, and local treatment options were limited, and misconceptions prevailed in Tanzania's Mbeya regions. Only half of survey respondents could name three or more indications of a child who should be referred for HIV testing. Further, only 64 percent of children's caregivers surveyed were aware of nearby paediatric HIV facilities, and only half of respondents were aware that paediatric antiretrovirals (ARVs) are a lifelong commitment (USAID, CDC and Elizabeth Glaser Paediatric Foundation (2006).

Lack of awareness of where the facility was located, especially in the Nairobi's sub-sample was a hurdle. About 23% of caregivers said they had not attended the facility because they did not know of it, compared to zero percent of the respondents in Eastern and Nyanza provinces, largely because the hospitals in the latter facilities are known district and provincial hospitals, or are the only major hospital in the case of Kendu Bay Mission Hospital. The Nairobi health facilities, on the other hand, are located in crowded and densely populated slum areas, where there are numerous other privately-owned facilities, both licensed and unlicensed. This suggests that appropriate signage and branding of health facilities offering quality pediatric services is particularly important so that the public can be informed where to take their children for testing.

2.9 Attitudes and Practices of people towards HIV testing and treatment

Attitudinal barriers still present a major obstacle that deters parents and caregivers from seeking paediatric HIV testing and treatment. Although some research participants in Malawi were aware of the tremendous health gains experienced by children on ARVs, the widespread belief that a child who is HIV positive is a "lost cause" still persists (Phiri and Graham, 2006). These attitudes still equate HIV with death especially among young and sickly children, and many participants in the qualitative research reported reluctance among community members to invest resources in such children under such pessimistic scenarios.

Myers (1986) reveals that if people feel embarrassed about their ailment, if they think the likely benefits of medical attention or counselling are not worth the anticipated inconvenience, or if they already want to avoid potentially devastating diagnosis, they may delay seeking help. The bottom line according to Cohen and Trusell (1996:3) is that "the societal context within which people are born and raised, are initiated to sexuality, and lead their lives strongly influences their perceptions of risk particularly to HIV and AIDS".

According to Bourdillon (1998), any death is likely to be attributed to witchcraft, for example sickness of a pregnant mother or child soon after birth and an abortion or the death of small children is often interpreted as witchcraft on the part of the mother. Though innocent, the mother is made to bear the psychological trauma wherever she goes. The children who are mostly marginalized constitute the future generation of Zimbabwe and other countries and failure of them accessing ART may mean underdevelopment.

2.10 HTC service providers

Youth want counselors who can give them accurate information in a friendly way by "youth-friendly". Young people mean that the counselor will not scold them for being

sexually active or be judgmental about the young person's behaviour (Juma and Likwele, 2004).

The lack of clear policies around testing in many countries, coupled with the overall lack of clarity about providing youth with reproductive health services, places providers in a stressful position. A Kenyan study concluded that VCT services for the youth need to be based on clear policies about testing, distribution of condoms to youth and stigma and discrimination (Laibutu, 2002).

Uncertainly on the part of providers regarding how to properly counsel children about HIV is one reason for health care providers' reluctance to initiate HIV testing. Counseling children requires skills that are different from adult and adolescent. HIV counseling and providers must have access to adequate training and tools of this area. These skills include assessing maturity, offering age appropriate communication and informing a child of his or her status. It is therefore essential that health care workers be adequately informed and equipped to provide counseling for children. Counseling for children should ideally be provided by health care workers or care providers trained or experienced in working with children. (WHO and UNICEF, 2010).

Establishing services that satisfy youth, parents and other community members requires working with all of these groups so that each group appreciates the concerns of the

others. Often concerns conflict as for example within parental restriction on testing seems intrusive to some youth but protective to many adults (McCauley, 2004).

Health care workers recommending HIV testing and counseling for children should be aware that testing a child most often implicitly tests that child's mum. Parents may refuse to allow testing of their children basing on this or other reasons. For example in Uganda many untested youths reported fearing that both medical staff and other clients would engage in stigma and gossip towards them if they entered a VCT facility no matter what their results were (Kirumira, 2003).

According to Juma, McCauley, Kirumira, Kakande, (2004b) to improve the provision of VCT, programmes need to do better understand to whom youth turn when making decision about HIV testing. Supportive relationships may minimise the negative consequences of testing that youth fear including stigma and isolation.

At a WHO meeting held in March 17-21, 2003 in Montrex, Switzerland entitled "Consultation on the health services response to the prevention and care of HIV and AIDS among young people" participants felt strongly that there are ethical and practical reasons for strengthening the ability of programmes to refer youth for other services. Most considered it unethical to provide testing without ensuring that the required treatment, care and support elements were in place.

Testing for young people are also clearly needs to be linked to other effective non-clinical interventions such as rape counselling, post-test clubs or community ant-AIDS clubs (WHO et al 2003). '...Although it is clear that the programmes could refer clients to preventive or palliative care' (Kakande et al, 2003).

HTC should be recommended by health care providers for all infants born to HIV+ women as a routine component of follow up care for HIV exposed children as well as for children from families with where another sibling or parent has already been diagnosed with HIV. (WHO and UNICEF, 2010).

2.11 HIV treatment, care and adherence

It is important that HIV infected children are diagnosed as quickly as possible, so they can be provided with appropriate medication and care. However, testing children for HIV can be complicated, especially for those recently born to HIV-positive mothers. Antibody tests, which are used to diagnose HIV in adults, are ineffective in children below the age of 18 months. Instead, children below this age are usually diagnosed through polymerase chain reaction (PCR) testing and other specialist techniques. This is referred to as early infant diagnosis and is important because mortality is very high amongst HIV infected infants who go untreated. However, among 65 reporting countries, it was found that only an estimated 28 percent of children born to HIV-

positive mothers received an HIV test within the first two months of life. WHO/UNAIDS/UNICEF (2011). For children who have lost one or more parents to AIDS, an estimated 95 percent live with a surviving parent or extended family member. International HIV/AIDS Alliance / Save the Children (2012).

HIV care and treatment is complex and drug regimens must be carefully adhered to, requiring consistent and meticulous monitoring (Steele and Grauer, (2003) and van Rossum, (2002). There is also need for the support of various actors, frameworks and systems, including the child, guardian, community members, the child's cultural heritage and the health care system available (Haberer and Mellins (2009) and Vreeman, 2009) as well as fears of disclosing HIV status to friends and family and lack of support from family and community. Some obstacles are unique to children's ART adherence. These include the barriers related to the age and physical and mental capabilities of some guardians. Some guardians forget to dispense drugs when the child appeared healthy—frustrating nurses and compromising the quality of important guardian-nurse relationships (Campbell, 2011b).

According to recent studies, ART regimens require 70–90% adherence in order to be effective Wensing, J (2008). However, sustaining adherence to antiretroviral therapy (ART) over the long term requires accurate and consistent monitoring, and this is a particular challenge for countries in sub-Saharan Africa. Adherence is defined as taking

medications or interventions correctly according to prescription. They include direct methods such as biologic markers and body fluid assays, or indirect methods such as self-report, interview, pill counts, pharmacy records, computerized medication caps, and viral load monitoring.. It is known that mothers tend to hide HIV infection status from their children and disclosure is often delayed until adolescence. (L. Armistead et al (2001).

Reddi, Leeper, Grobler, Geddes, KH France, GL Dorse, and Vlok 2007 show that only 7.9% children had been made aware of their own HIV infection status in their study in South Africa. Disclosure of HIV infection status is a critical step and has obvious implications for adherence. Starting the disclosure process as early as 8-9 years of age and combining it with specific support, as suggested may result in increased adherence in children. There are similar reports that indicate lack of disclosure as predictors of poor adherence in adults Bajunirwe, (2009).

Social or family stigmatization and fear of the consequences of revealing HIV infection status to sexual partners are closely related to poor adherence, J. B. Nachega, D. M. Stein, D. A. Lehman (2004). "Adherence to antiretroviral therapy in HIV-infected adults in Soweto, South Africa," AIDS Research and Human Retroviruses, (2004). Family plays a crucial role in any kind of treatment in children E. Pontali, (2005).

However, although the number of children receiving antiretroviral therapy (ART) has increased significantly in recent years, at the end of 2010 only 23 percent of the 2.02 million children in need of ART in low- and middle-income countries were receiving it. WHO/UNAIDS/UNICEF (2011).

Providing treatment for children with HIV and AIDS essentially involves three stages: finding a child, testing a child and treating a child. Most children living with HIV become infected through mother-to-child transmission, and these children need to be tested as soon as possible after birth to find out if they are infected with the virus. If a child living with HIV is only diagnosed once they are ill, it may be too late for antiretroviral treatment to be effective.

HIV testing among children born to mothers living with HIV remains low. Whilst the World Health Organization (WHO) recommends that infants be tested within two months of birth, the proportion of infants tested within two months, among 65 reporting low- and middle-income countries, stood at 28 percent in 2010. WHO/UNAIDS/UNICEF (2011). However, this is an improvement compared to the 6 percent coverage in 2009. WHO/UNAIDS/UNICEF (2011).

A number of factors may prevent children from being tested. These include health authorities' lack of technical ability, poor systems for laboratory analysis, and problems

with transportation of specimens and results, and low confidence among health care providers in caring for children. UNICEF/WHO (2008). Furthermore, parents may be unwilling to take their child for an HIV test for fear that the child will face prejudice once diagnosed. A lack of knowledge about the existence of antiretroviral therapy to treat HIV and therefore the point of getting an infant tested could also lead to poor testing rates. Mothers who have not yet been tested may be fearful of discovering their child is infected, as this would be likely to mean they are infected also. Support and advice for parents and carers around disclosing, caring for and supporting a child living with HIV, and addressing some of the myths and prejudice around the condition, can make testing and treatment far more successful Chiva, (2011)

Among older children, there is a complex balance between the immediate benefits of providing treatment to children who are not showing any symptoms of AIDS-related illness, and concerns about long-term resistance and antiretroviral drug side effects if treatment is started too early.

- The increased burden of adherence that comes with a longer overall period of treatment. Welch and Gibb (2008),
- Unfortunately, a lot of HIV medicine has an unpleasant taste, especially in syrups and powder form. This can make it difficult for children to take their ARVs daily. In addition, it is critical that children's medicine has clear and

concise labeling to ensure that caregivers are able to give an appropriate dosing and ensure adherence.

Mothers need to demand care for their children and remind the decision makers of the moral imperative" – Shaffiq, *(2012.,* Most children on HIV treatment need to take three or more types of ARVs every day for the rest of their lives. If drugs are not taken routinely at around the same time every day, HIV may become resistant to the therapy, causing it to stop working.

For instance, carers may be reluctant to fill out prescriptions in their local community, or may not make a child's school aware of their condition, which can lead to them missing out on drug doses during the school day. The Guardian, (2012). They may also hesitate to administer ARVs if other people are present when a child is due to receive them. "It's partly because I have to live this life of shame and secrecy that I find it so hard to take my meds." *Young person living with HIV Mbori-Ngacha, Dorothy 2011.* "There are days when I can't be bothered [to take my medications] like when I am tired or if I am at someone else's house and have to hide it or whatever, then it's hard."*13 year old HIV-positive girl (*Chintu and Mwaba, (2005).

Among older children and adolescents, a variety of social factors such as fear of stigma and discrimination, stress and anxiety and peer relations impact treatment adherence. Murphy DA (2005). Side effects, and the need to take treatment at different times of the

day, also explain why adolescents may find it difficult to adhere to their treatment regimens. Reisner, (2009).

2. 12 HIV testing methods

In Zimbabwe HIV infection is usually diagnosed by testing for antibodies against HIV. The commonly used screening tests for HIV antibodies include Enzyme-linked immunosorbent assay (ELISA) or simple rapid tests. (Zimbabwe National Guidelines on HIV testing and Counselling, 2005).

i) HIV testing of children less than 18 months

Antibodies to HIV can be passed from mothers to their babies through the placenta and breast milk and may be present in the baby's blood for up to 18 months after birth. This means that it may not be possible to determine whether a baby is HIV infected using HIV antibody tests until the baby is older than 18 months. However, there are virology tests that can be performed in this age group such as deoxyribonucleic acid (DNA) ribonucleic acid (RNA) polymerase chain reaction (PCR) tests, P24 antigen test and viral culture. (Zimbabwe National Guidelines on HIV testing and Counselling, 2005).

ii) Enzyme-linked immunosorbent assay (ELISA)

ELISA tests are used in both public and private hospitals and clinics where there is a laboratory. Results can be obtained the same day or two weeks later, depending on the workload. This is one of the reasons for greater reliance on simple rapid tests that deliver

same-day results. (Zimbabwe National Guidelines on HIV testing and Counselling, 2005).

ELISA tests were originally developed for donor blood screening and therefore are more suitable for batch testing in settings where large numbers of clients are seen. Laboratory Scientists using specialized equipment can only perform these tests. (Zimbabwe National Guidelines on HIV testing and Counselling, 2005).

iii) Simple or rapid tests

Rapid tests are recommended for HIV testing and counselling services. They are simple to perform, even in clinics without laboratories or specialized laboratory equipment, and are as accurate as ELISA tests when Standard Operation Procedure (SOP) are followed. A very small sample of blood is taken from the client's fingertip, and the result is ready within 20 minutes. (Zimbabwe National Guidelines on HIV testing and Counselling, 2005).

2.6 Summary

The chapter looked at the barriers to uptake of HIV testing and counselling among minors. The policy implications on the issue of access to the HIV testing for minors were also discussed. The knowledge and, awareness, attitudes and practices of people towards HIV testing and treatment were discussed. The next chapter will then look at the methodology to be used to come up with results following the stated objectives.

CHAPTER 3 RESEARCH METHODOLOGY

3.1 Introduction

The chapter outlines the study design, study population, sample size, sampling method, data collection techniques, data processing and analysis and ethical considerations in the research process. The study at hand is primarily qualitative, although it rests on some quantitative data collection techniques and presentations.

3.2 Research Design

The researcher used the descriptive survey, Commack, (1994) maintains that a descriptive survey research designs involves systematic collection of information and aims at discovering and describing facts about the situation, people's activities or events. The survey research design was found to be advantageous in this study because Owens, (2002) found it "As generally yielding highest cooperation and lowest refusal rates. In addition, it also has high response quality as it takes advantage of interviewer's presence". Giddens, (1997:548) also indicates that "surveys make possible the efficient collection of data on large numbers of respondents" this may then allow a precise comparison to be made between answers of respondents.

3.3 Sample

Even if it were possible, it is not necessary to collect data from everyone in a community inorder to generalize findings. The researcher used qualitative approach. This was through questionnaires and interviews. In qualitative research only a sample (that is, a subset) of a population is selected for any given study. Best and Kahn (1993) describes a sample as a small proportion of a population selected for observation and analysis. It is a representative of a smaller part of a population from which it is selected. Therefore, the study's research objectives and the characteristics of the study population (such as size and diversity) determine which and how many people to select. In this case, a convenience or availability sampling was used. In this case, the sample size was 44 minors and 16 parents and or guardians and 10 HTC service providers as key informants. A guiding questionnaire was administered for the children under the age of 16 and parents and guardians were interviewed using an interview guide. The nurses from Mutare clinics, youth friendly coordinators were also interviewed as key informants. This type of sampling rests on the closest and most available samples (Giddens, 1997). This is therefore convenient for the researcher as it is less expensive and requires little effort considering that the researcher has time constrained.

3.4 Data collection plan

The data was collected using the self administering questionnaires and one on one interview. The researcher interviewed the parents and or guardians one by one in a

separate room and taking down the information. The data from the under 16 was collected using the questionnaires which were administered from the youth friendly centres in Mutare urban.

3.5 Ethical consideration

Permission to collect was sought from the Institute of Peace and Governance, Africa University, Mutare city council health department and the National AIDS council, Manicaland. Confidentiality is the protection of the participants in a study such that their individual identities will not be linked to the information they provided and will never be publicly divulged (Polit & Hungler, 1989.). No names were used but only numbers, and participants were not asked about their HIV status. Use of numbers instead of names ensures anonymity and confidentiality. Furthermore, participants were told that they have the right to participate or not and that they can withdraw at any time during the study. They were also informed that this information will be considered confidential and they have the right to withdraw any time during the data collection process and they will not be victimized.

3.6 Plan for dissemination of the research findings

Data collected from the interviews was presented in the form of a report and analysis was made with the use of graphs, pie charts and comparisons with existing literature cited in Chapter two. In order to clarify the data interpretations and simplifying them,

accompanying comments were made under each item. Recommendations were also done and the time frame expected to carry out the recommendations.

3.7 Summary

This chapter concentrated on methods and procedures in data collection and analysis. This included a discussion on methodology, research design, population, sampling, data collection instruments, ethical considerations, data analysis and interpretation. The next chapter will present, analyze and interpret the data that was collected from the respondents as findings.

CHAPTER 4 DATA PRESENTATION

4.0 Introduction

This chapter presents the findings on the assessment of HIV testing and counseling uptake among minors case of Mutare District. The findings were presented and analysed in the form of tables, graphs and charts. Data was collected from a sample of 70 respondents who were conveniently sampled in Mutare District. These are 10 service providers as key informants, 16 parents/guardians and 44 children of 16years and below. The parents/guardians were of different ages, as well as academic levels. As stated earlier, the major objective of this study is to assess the uptake of HIV testing and counseling among the minors.

4.1Presentation Of Findings

4.1.1Demographic Characteristics Of Study Participants

Table 1: Distribution of participants by age

Parents/guardians:			**Children**		
Age group	**Frequency**	**Percentage**	**Age group**	**Frequency**	**Percentage**
>20	0	0%	>5		0%
20-30	8	50%	5-10	6	13.6%
30-49	6	37.5%	10-15	32	72.7%
50+	2	12.5%	16+	6	13.6%

Table 1 and shows the age distribution of participants for children and that for the adults. The majority of the participants for parents were between the age of 20-30 years (50%) and that for children were participants between the age ranges of 10-15 (72.5%). The reason for more participants in the age ranges 20 to 30 might be attributed to the fact that this is where the reproductive age group falls according to the Demographic Health Studies of Zimbabwe (DHS 2008).

Table 2: Gender, educational level and HIV testing

Distribution of participants by gender			**Level of education of parents and guardians respondents**			**Number of participants tested and Not tested for HIV**			
Age group	**Frequency**	**Percent**	**Level of education**	**Frequency**	**Percentage**	**Age-group**	**Tested**	**Not tested**	**Total**
Young men	26	**59%**	Grade 7	1	6.3%	Adults	14 (87.5)	*2 (12.5)*	16 (100%)
Young women	18	**41%**	Ordinary Level	13	81.3%	Children	4(9%)	40 (91%)	(100%)
Adult men	6	**37.5%**	Diploma	1	6.3%	Send child for HIV test	12 (75%)	4(25%)	16 (100%)
Adult female	10	**62.5%**	Degree	1	6.3%				

Table 2 shows the composition of subjects that were interviewed and their gender, Education level and those who have been tested and not tested before. The majority of the respondents 13 (81.3%) passed through ordinary level education except for the 1 (6.3%) who attained grade 7. That made the work easier because most of the respondents were able to respond to questions to the best of their knowledge. The fact that it was an interview, the researcher explained in Shona, which is their mother language for them to understand; this came out to be an advantage of the instrument used hence a true reflection of what was on the ground.

4.1.2 Knowledge about HTC:

Figure 1: Knowledge about HTC

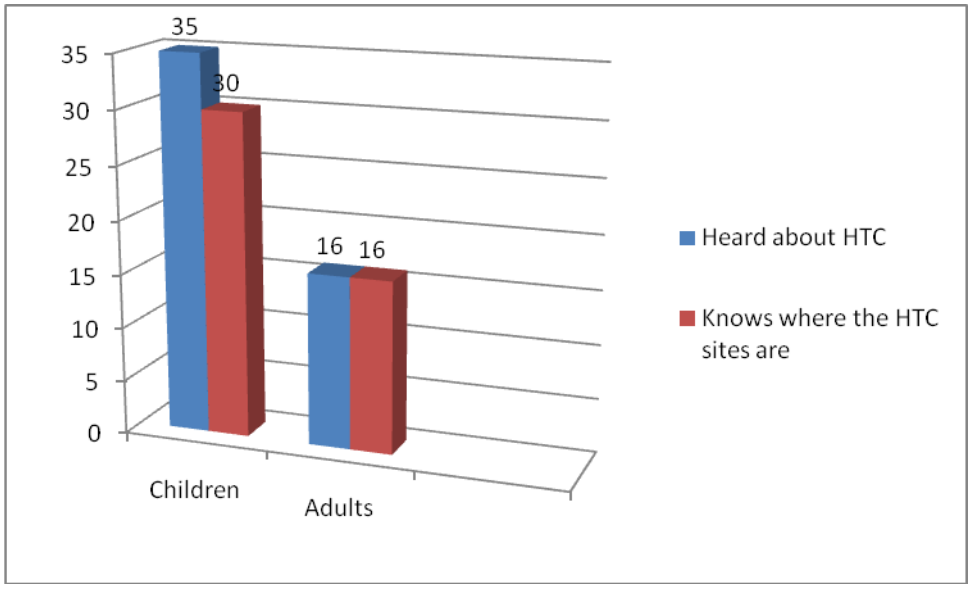


Fig 1 depicts the number of respondents who have the knowledge on HIV testing and

counselling. This was expressed from whether the respondents have heard about HTC before and whether they know where the HTC sites are. From the graph above there is an indication that all the parents (100%) have heard about HTC before and they know where the sites are**.** For the children (79.5%) indicated that they have heard about HTC before and (68.25%) indicated that they know where HTC sites are**.**

4.1.3 Why parents and guardians do not take their children for HTC

Figure 2: Reasons for not taking children for HTC

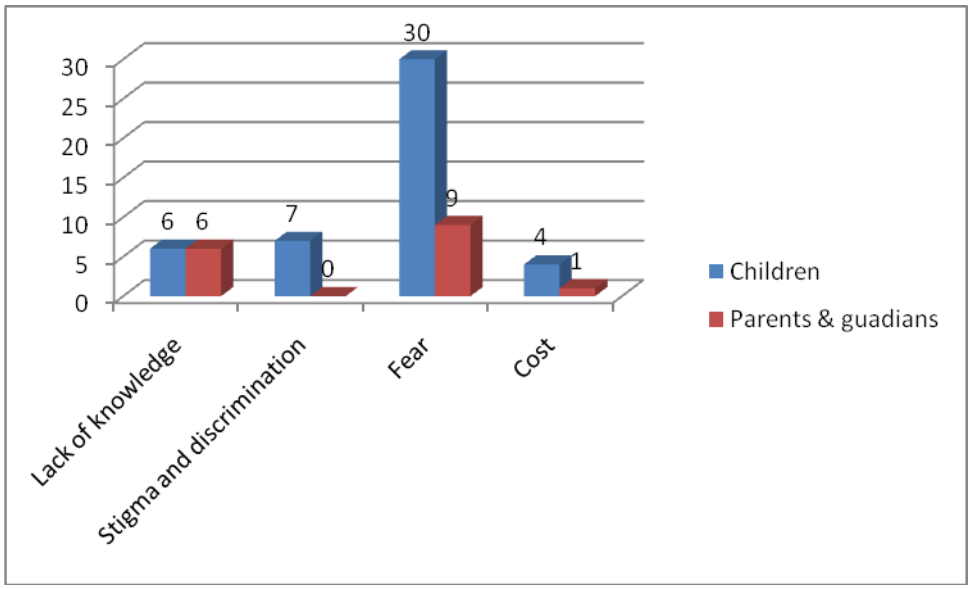


Fig 2 shows reasons why parents do not send their children for testing. This is from the parents and children's perspective. The study found out that both children and parents cites fear as the major hindering factor. 30(68%) of the children and 9 (56%) of the parents cited fear of the unknown as the main barrier to accessing the HTC services.

Table 3: HIV disclosure

Responses to HIV status disclosure to children			**Children who know their parents' HIV status**		
	Frequency	**Percentages**		**Frequency**	**Percentages**
Male	1	6.3%	Male	8	18%
Female	4	25%	Female	6	13.6%
Total	5	31.3%	**Total**	14	31.8%

Table 3 above indicates the number of parents and guardians who find it important to disclose the children HIV status to the children as well as the children who knows their parents and guardians' HIV status. The issue of disclosure is regarded as traumatising to the child hence most adult respondents thought that it was not necessary to disclose their status to their children. The parents stated that at the age of under 16 children might fail to comprehend and this might end up affecting them socially. Some children might end up disclosing this information to their friends and the whole community might end up knowing that they are HIV positive hence facing discrimination.

4.1.6 The right age for children to get tested for HIV without parental consent

Table 4: The right age for HIV testing

	>5	5-10	10-16	16+
Young men	0	7	9	10
Young women	0	5	5	8
Adult men	0	0	1	5
Adult women	0	0	4	6
Total	0	12	19	29

4.1.7 Parents and guardians discussing HIV issues with their children

Figure 3: Parents and guardians discussing HIV issues

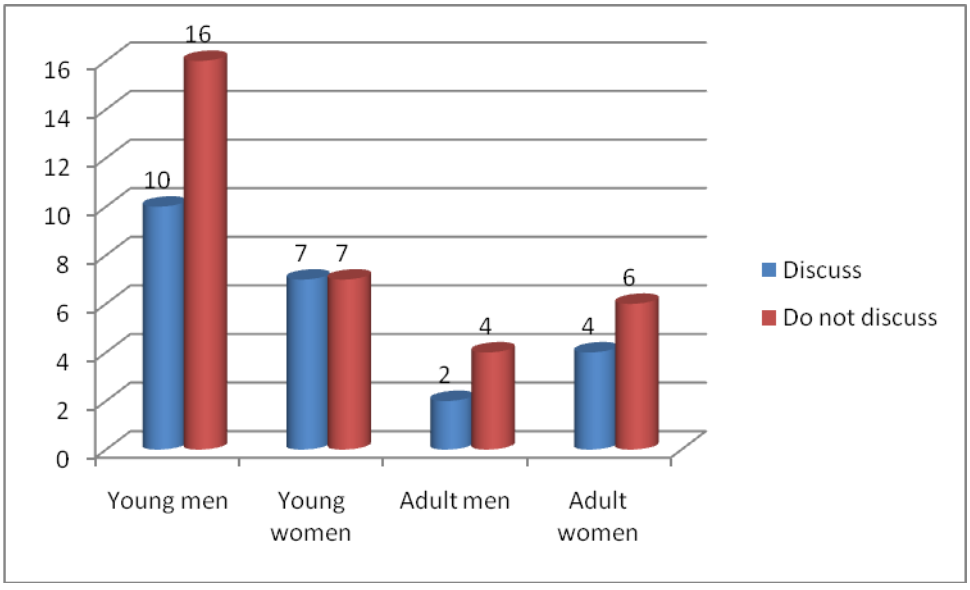


Fig 3 Above shows the responds on whether parents discuss the issues of HIV with their children. 17 (38.6%) of the children stated that they discuss the issues of HIV with their parents while 6 (37.5%) of the parents also said they discuss about HIV with their children. However for those who said they discuss about HIV they said at a lower scale since they feel that children might not understand issues of HIV.

4.1.8 How HIV is transmitted

Figure 4: How HIV is transmitted

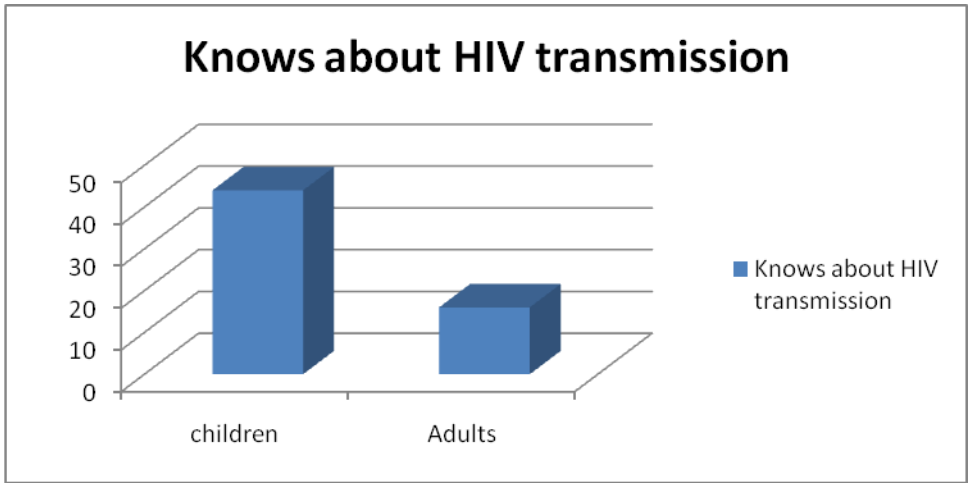


Fig 4 above shows the knowledge levels of parents/guardians and children on how HIV is transmitted. All the respondents showed that they have knowledge on how HIV is transmitted.

4.1.9 Importance of Prevention of mother to child transmission.

Figure 5: Importance of prevention of mother to child transmission

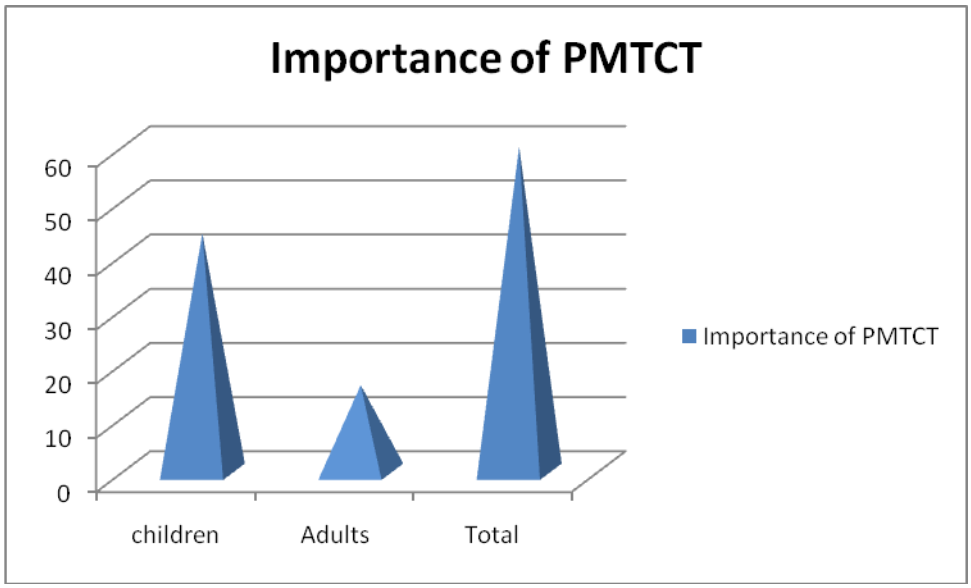
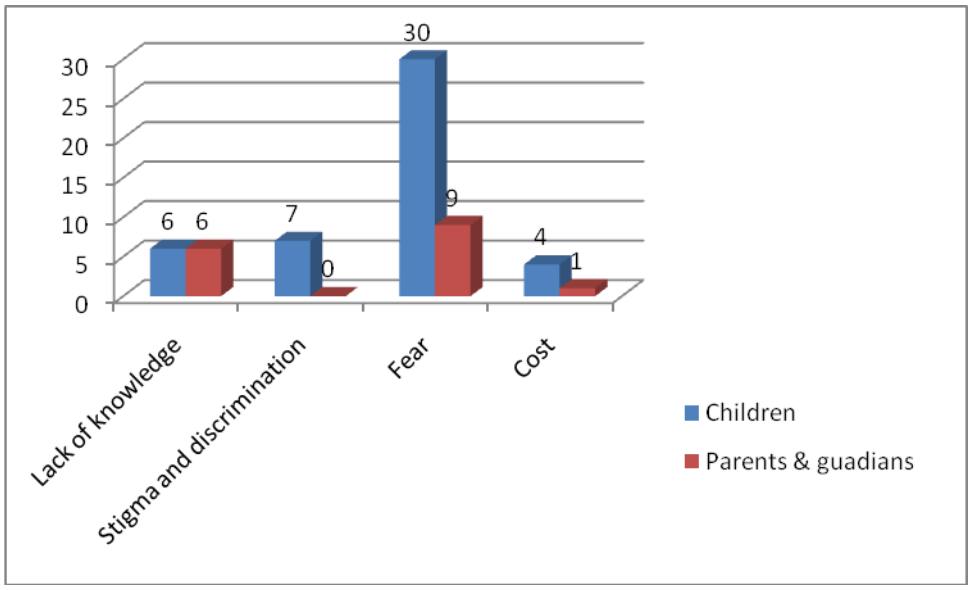


Fig 5 illustrates the views of the respondents on the importance of Prevention of mother to child transmission during the pregnancy of the mother . all the respondents upon being asked whether they think its important for all the pregnant mothers to go for PMTCT they said it was important.

4.1.10 Barriers to HIV testing and counselling for the children.

Figure 6: Barriers to HTC for children



From the responds about the barriers for children's HIV testing most respondents 9 (56%) and 30(68%) children cited fear as the major barrier. In addition to that they reported that the information they had was that children should be tested and get treatment early to avoid complications. However the knowledge gap was at what stage a child was supposed to be tested for HIV and get treatment. Those who lacked information alluded to the fact that they were not involved, because they assumed that a person usually gets information when he or she is into something.

4. 1.12 Knowledge on whether a healthy looking person can be HIV positive

The survey further explored respondent's beliefs about whether a healthy-looking child could be HIV positive. (100%) of the respondents said that a healthy-looking child could be HIV positive.

4.1.13 Health workers disseminating information about HIV

Figure 7: Health workers disseminating information about HIV

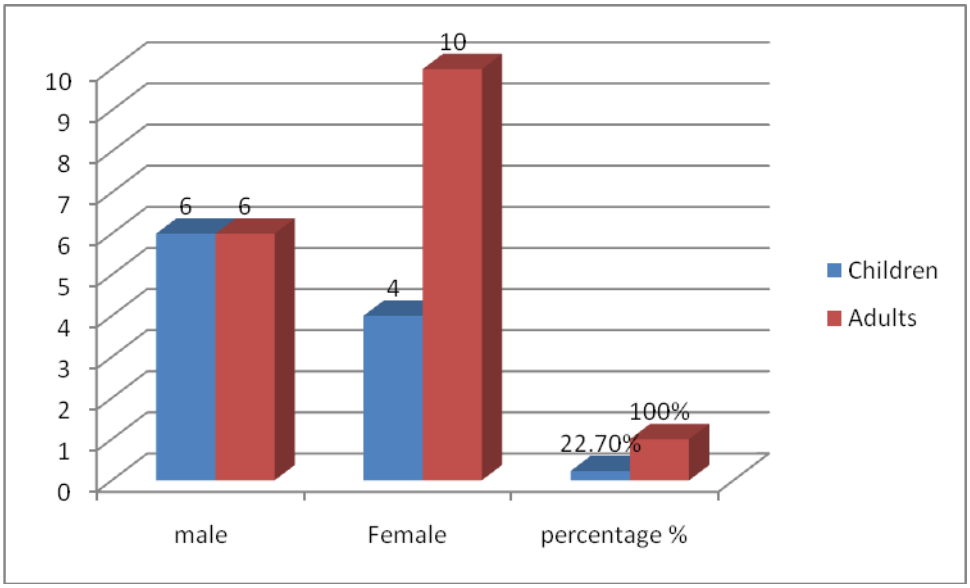


Fig 7 presents the number of respondents who agree that health workers talked to them about HIV and AIDS when they visited the health centres. Only 10 children (22.7%) cited that the health workers talk to them about HIV. However all the parents and guardians said that the health workers talks to them about HIV and AIDS. These results indicate that the issues to do with HIV are regarded as adult issues. The children are not being given enough education when they visit the health centres. The provider initiated

HIV testing and counselling is targeting mostly the adults since they are the once who would have brought the children to the health centres**.**

4.1.14 HIV person can live longer while on ART

The researcher interviewed the respondents in order to understand the attitudes of the respondents on the effectiveness of paediatric ART. All the 60 (100%) participants said they believed a child could live longer and healthier after getting treatment and adhering to it. When compared to a research study carried out in Tanzania by USAID, CDC, and EGPAF (2006), the results do not tally because in Tanzania only half of the respondents which is 50% were aware that paediatric ART was a lifelong commitment and fears and misconceptions still prevail because of lack of in-depth understanding of paediatric ART. The reason why the study group in this current study believed so is that they had living experiences of children who are on ART and are living as healthy as any other child. In Tanzania, the knowledge gap might be attributed to the fact that paediatric ARVs were not so popular and a few had access to information related to that. Paediatric ART programme was viewed by all as a worthwhile cause.

4.1.15 Attitudes towards children's illness

Figure 8: Attitudes towards children's illness

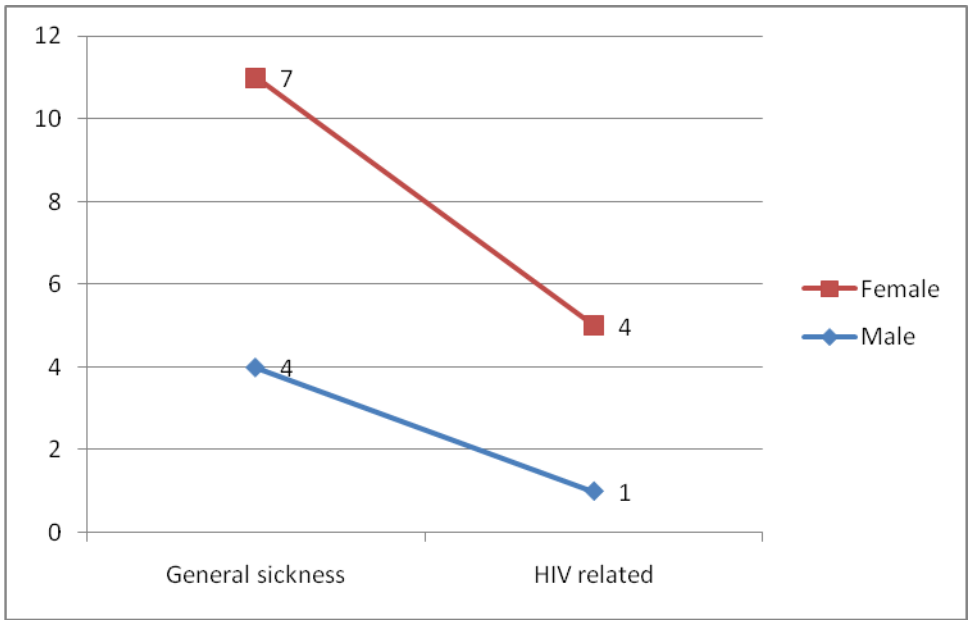


Fig 8 shows that 11 (68.7%) out of the 16 respondents said that if their child falls sick they will only regard it as general sickness. 4(32.3%) said they will think their child is HIV+ when their child falls sick. Some stated that it will depend on the environment where the child is and the trend of the sicknesses other children are suffering from. Other respondents stated that if the child's parents had been diagnosed with HIV then if the child falls sick that's when they think that the child might be HIV positive.

4.1.15 Where to seek treatment first when the child falls sick

Figure 9: Seeking treatment when a child falls sick

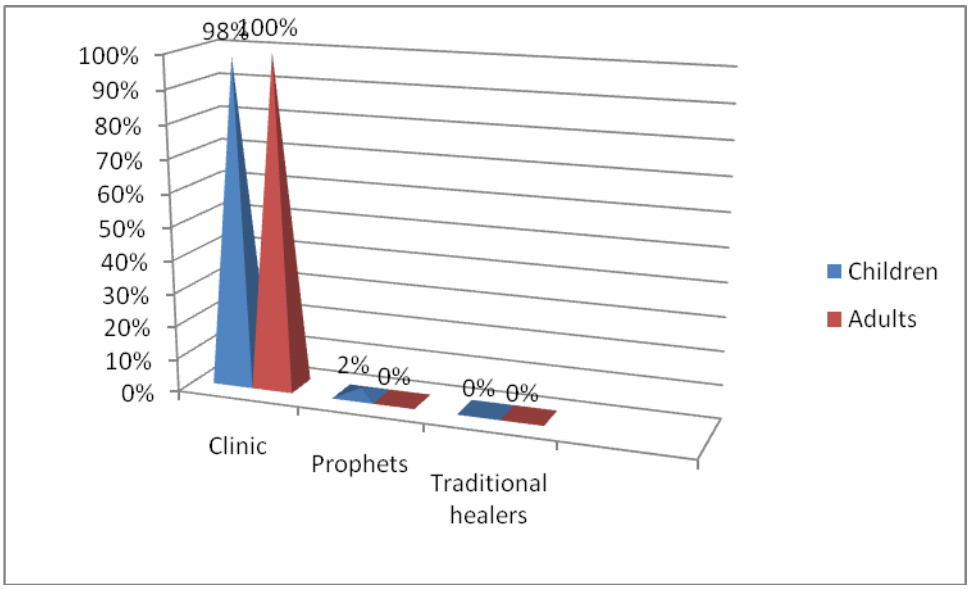


Fig 9 above presents the attitudes of parents/guardians on the possible causes of children's illnesses through seeking of treatment. According to the children 98% of the respondents said they seek treatment from the clinics first and 100% of the adults also concurred with the same view.

4.1.16 Reaction on whether minors should know their HIV status and whether they are able to manage their HIV status

Both the minors and the parents were in agreement that minors should know their HIV status. However 89% of the children stated that children are able to manage their own status while 93% of the parents/guardians also stated that children can manage with proper and continuous counselling.

4.1.17 Responds on whether children are sexually active.

The responds on whether the children under the age of 16 are sexually active were 29 (66%) of the children and 14 (94%) stated that they believed that children are engaging in sexual activities. The parents stated that most minors are sexually active especially girls. The population which was under study is that in the urban setup where they said children are exposed to televisions and internet. This exposure leads children to engage into sexual activities at early stages. Some even said some children engage innocently at tender age of pre-school through playing not knowing the risks involved. Some parents shares same bedrooms with their children hence the children also imitate them at very tender age.

4.1.18 Existence of Stigma and discrimination within the communities

Figure 10: Stigma and discrimination

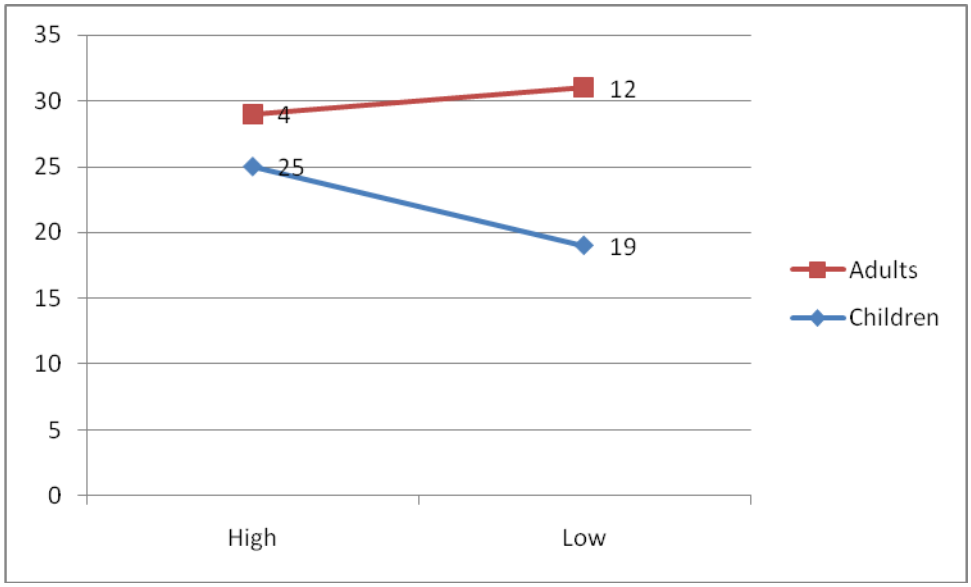


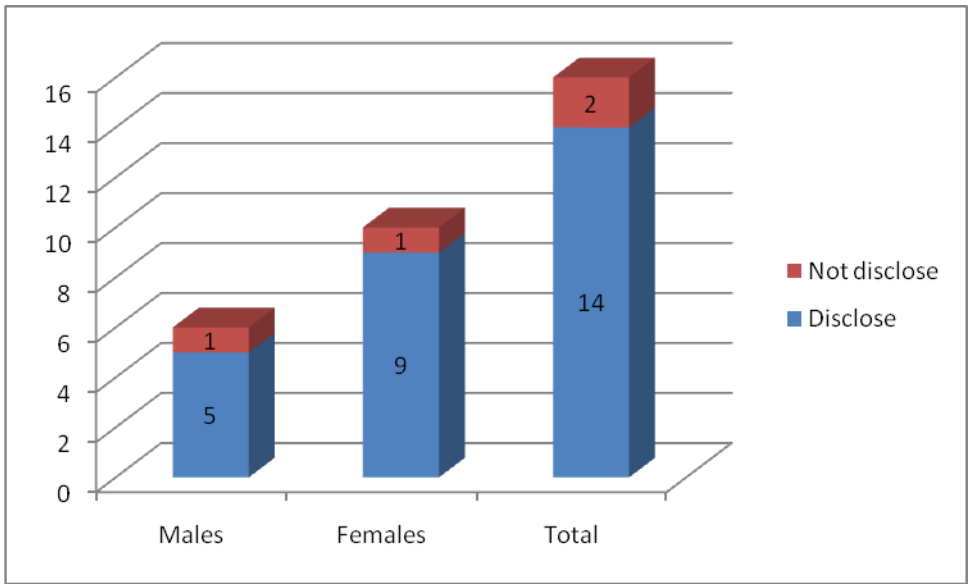
Fig 10 above shows the responds on whether stigma and discrimination is still high in the commuinites. According to the children 25(56.8%) believed that stigma is still very high. This is because some children laughs at other children who are said to be HIV positive or those children whose parents have died of HIV. This is said to be rampant at schools where children meet and spend most of the time at. However most parents/guardians 12 (75%) believed that stigma and discrimination is now very low comparing to the past days when HIV was identified when it was given names like *" shuramatongo or mukondombera*".

4.1.19 Give consent for their children to get tested

100% of the parents/guardians agree that they will give their children consent for HIV testing and counselling. Most parents stated that they would go with their children for their test so as to offer them support. Some parents said that will depend on the age of the children, if they are below the age of 10 they will not disclose.

4. 1.20 Disclosure to the minors if they are taking Anti-retroviral drugs

Figure 11: Disclosure to the minors if they are taking ARVs



The graph above shows the parents/guardians' responds on whether they will disclose to their children if they are taking ARVs. 14 (87.5%) of the respondents indicates that they will disclose so as to encourage adherence. However most respondents indicates that this will depends on the age of the children, if they are under the age of 10 they will not disclose for the children might fail to understand the meaning of ARVs.

4.1.21 What can be done to increase the uptake to HIV testing and counseling among minors.

From the responsends from the parents guardians they recommend that HIV and AIDS education should be intergrated in schools so that children understand about HUV from the early ages. Most children 30 (68.2%) respondnts failed to come up with suggestions. This indiacates that they do not understand much about HIV programmes which suit them. However some children also sugested that HIV should be a subject at school which is examined at the end of term just like any other subjects.

4.2 Summary

This chapter focused on the findings from the interviews and questionnaires which were administered for the minors that were contacted with respondents from Mutare urban district. Prior to analysis, the background of the respondents was given and analyzed. Data was presented descriptively, tabulated and expressed on graphs and pie charts depending on the type of information. Chapter 5 will give a summary of the whole research study, a conclusion and recommendations.

CHAPTER 5 DISCUSSION AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses the findings presented in chapter four and come up with recommendations. The chapter also answers the research questions raised in this study using its findings as presented mainly in chapter four linking them to previous research studies captured in chapter two. It also concludes by evaluating on the objectives of the study and giving recommendations based on what came out of the data analysis.

5.1 Discussion

5.1.1 Respondents tested and not tested: there is an indication that the number of children that were tested was low (9%). However the responds for the parents/guardians was different where a total of adults respondents (87.5%) were tested. This concur with the data collected by the National AIDS Council in Mutare urban district where in 2012, of the 15038 people who were tested 280 (1.9%) were children were children of 15years and below. This might have been necessitated by the fact that most of the parents/guardians said they would wait for their children to become sick failure of which they would not seek medical attention. Although some parents did not want to get tested themselves as well as their children, they were aware of the benefits associated with knowing their children's status which included, knowing how to deal with the child's health, to be aware of the kinds of food to give the child if he or she is found positive, for the children to be initiated on ART early and avoid complications or continue

receiving the wrong medication, to avoid major risks, to be aware of the signs and symptoms, in order to live a happy life which is free of stress, to get assistance from relatives and community in terms of information and to avoid misconceptions like witchcraft accusations which lead to an unstable society after pointing fingers at each other.

This study's findings concurs with the estimates based on surveys in 12 high-burden countries in sub-Saharan Africa indicate that a median of just 12% of men and 10% of women in the general population have been tested for HIV and received the results. World Health Organization, (2007). Even in more developed countries, about 20% to 30% of seropositive individuals are unaware that they are HIV positive. De Cock KM, Bunnell R, Mermin J.(2006.)

5.1.2 **Why parents and guardians do not take their children for HTC**

The study found out that both children and parents cites fear as the major hindering factor. 30(68%) of the children and 9 (56%) of the parents cited fear as the main barrier to accessing the HTC services. This was followed by 6 (37.5%) of the parents who cited the issue of lack of knowledge as another factor which makes parents fail to take their children for HTC. The same number of children 6(13%) of children also cited lack of knowledge as a barrier for parents to take their children for HIV testing and counselling.

7 (15.9%) of the children stated that stigma and discrimination was another hindering factor. The other constraining factor was cost as some of the participants amounting to 4 (9%) children and 1 (6.25%) parents reported that sometime the cost factor as parents are afraid of the costs associated with medication in the event that the child tests HIV+. The reasons given for not testing the children were also centred on the parents/guardians' attitudes towards their own testing and that of their children. Although there is the Prevention of Parent to Child transmission (PMTCT) programme which prevents unborn children from contracting HIV, the research findings revealed that the PMTCT programme yielded low uptake as female parents/guardians themselves were not willing to get tested themselves hence could not bother themselves to have their children tested as well. These attitudes also contributed to none testing of children. This is in agreement with UNICEF (2002), who carried a research in Botswana, who found out that less than 50% of women were actually tested indicating that most clients were reluctant to be tested or to know their results. Further on, the adult respondents in Mutare even highlighted that they believed testing is important when the child fall sick.

Stigma against HIV is reported to be pervasive and to be the main reason for the reluctance to be tested, to disclose HIV status, or to take antiretroviral agents. This has been documented in numerous countries, including South Africa, Indonesia, Tanzania, Botswana, Ethiopia, Ghana, India, Uganda, Thailand, and Zimbabwe Herek GM, Capitanio JP, Widaman KF. (2003).

For those parents/guardians who were not willing to take their children for HIV and AIDS testing reported that they had fears of stigma and discrimination that the child would face once diagnosed, which would result in the child being disturbed in social life and education. This was in line with results that were found by Mhambi (2007) at Hwange Colliary Company where the majority of the respondents who had not gone under an HIV and AIDS test was due to fear of results and being stigmatised as a result. According to the symbolic Interactionism theory, the meanings that a society give to something have either negative or positive connotations on one's life hence the meanings are socially constructed. This means that the individual actions are controlled by the society, thus as a result of this, a parent/guardian may choose not to have their children tested. With the feminization of the AIDS pandemic, patriarchy still play a dominant role in controlling women and the family at large.

The female parents/guardians pointed out in passing that men also contributed in a way to none testing of children because of their negative attitudes. Most of them revealed that their husbands said they did not want to hear of the issue of testing for the children. This means they were more reluctant to have the children tested yet it was to their benefit. In most cases, women were afraid to send children for testing in order to commence on ART because of the relational factors. Some said they were afraid of being divorced by their husbands and there was also the risk of being blamed for bringing the infection home.

These results were of practical relevance as was conducted by Phiri and Graham, (2006) in their research study carried out in Malawi, which found that non tested mothers were fearful of discovering their child is infected as this would likely mean they are also infected. Notwithstanding this, more often a child was tested for HIV after the mother has tested before. From the research findings, it was learnt that the mother could not bother having her child tested in the very early years after birth as she was aware of her status and felt the child will have the same status as well.

5.1.3 HIV status disclosure to children

The issue of disclosure as indicated on table 3 is regarded as traumatising to the child hence most adult respondents thought that it was not necessary to disclose their status to their children. The parents stated that at the age of under 16 children might fail to comprehend and this might end up affecting them socially. Some children might end up disclosing this information to their friends and the whole community might end up knowing that they are HIV positive hence facing discrimination. This concurs with what is embedded in the Botswana's National HIV and AIDS treatment guidelines, 2008 which states that aadolescents must receive disclosure of their positive HIV status in a supportive environment. The study also agrees with a qualitative study in Addis Abba by Biadgilin, Deribew, Amberbir and Deribe which noted that care giver characteristics have an influence in the adherence to paediartric ART. It also revealed that Potential barriers to adherence include non-disclosure of HIV status, poverty and nutritional problems, lack of social support, and absence of a private place to take the medicine

when relatives /neighbours came to their home, for fear of stigma and discrimination. Both the caregivers and health care providers reported non-disclosure as a significant barrier in handling HIV-infected children (Biadgilin, et al 2009).

5.1.4 HIV transmission modes

The views of how the respondents knew of the pandemic also included the infection from mother to child which is in relation to the need to have children tested. Generally the respondents had knowledge of how HIV can be transmitted**.** The respondents gave correct responses about the methods of transmission of HIV especially regarding sexual relationships and sharing of syringes and sharp instruments. In children they reported that it was through mother to child, during pregnancy, at birth and breastfeeding stages as well as child sexual abuse. Some participants knew more than one means of HIV transmission and a greater number knew how it was transmitted in adults alone and not in children. This implies that a lot of information disseminated on HIV and AIDS is more to do with the elder people sidelining the children who are the future generation. Most participants attributed HIV transmission to having unprotected sex with an infected partner and this concurs with the findings by McDaniel, Carson and Thompson (1995) in Kuwait. This might be because a lot of information has been disseminated through mass media communication like posters, radios and televisions focusing on the causes of HIV and AIDS.

5.1.5 **Knowledge on whether a healthy looking person can be HIV positive**

All the respondents agreed that a healthy looking person can be HIV positive. The reasons why the respondents said it was true is that, HIV was blood dormant and could not be seen by a naked eye unless tested. In addition to that it was revealed that the symptoms of HIV might not show up in its early stages though the child will be infected already, as a result, they found that it was necessary to have an HIV test even though the child was looking healthy. In contrast with the beliefs of other respondents, reasons level against the truthfulness of the statement that a child may have HIV even if she or he is looking healthy were that if the child was born of an HIV negative mother and was not exposed to any blood transmissions with an infected person automatically it proved that the child was HIV negative. These parents therefore revealed that they would not bother to have their children tested unless they become ill. Also the fact that HIV has signs and symptoms, the fact that the symptoms will not be exposed would mean that the child is negative. The signs and symptoms were identified as deterioration in weight, being sick all the time and having a pale skin. Furthermore, the research found out that usually the symptoms of HIV can be triggered by the types of food one consume and considering the poverty that prevails in that area and the genetically modified foods that are in circulation would make HIV symptoms more revealed.

5.1.6 **The right age for children to get tested for HIV without parental consent**

It was discovered that both the children and the parents 29 (48%) agree that the issue of

maturity is vital when it comes to the uptake of HIV testing and counselling of children. A total of 11 (68.8%) of the parents stated that the majority age should be reached before the children start seeking the HTC services on their own. 18 (40.9%) of the children also cited that the children need to reach the age of 16 before they seek the services on their own. Some parents stated that they will still escort their children so as to support them even if they are over 16 years because they are afraid that the children will not be able to accept the results on their own. Some parents explained that the age will also depends on the gender of the children, if they are girls they can go on their own at the age of 14 and above since some girls matures early and indulge in sexual activities earlier than the boys.

5.1.7 **Where to seek treatment first when the child falls sick**

Only 2% of the children said they would seek treatment from the prophets and none of the respondents believed that treatment should be got from the traditional healers. On further probing witchcraft accusations were said to be old fashioned considering the world of HIV people were living in hence would seek medical attention compared to traditional or prophetic treatments. These results were in contrast with findings by Cohen and Trussel (1996) in Nigeria where they believe disease causation is an act of a higher being or neighbour as a result people visited native doctors or prayer houses for assistance.

5.1.8 **Overview from the service providers' perspective**

From the interviews which was carried out from the HIV testing and counselling service providers the following was noted. The service providers were 4 youth coordinators from the Youth friendly centres, 2 councillors and 4 nurses from the city clinics. These were the key informants who gave an overall overview of the uptake of HIV testing and counselling services among the children under the age of 16.

It was noted that most parents who bring the children for testing are those who have been referred after the child is sick. The parents are encouraged to get tested also so that they get in the same level with their children. Though they are not forced it was observed that due to this initiative most parents/guardians will be reluctant to undergo the testing and counselling process hence they will not bring the children for testing. The service providers normally take the history of the child, if there are some indications of sexual abuse they might test the child only but if there is no history of abuse the then they strongly encourage the parent to get tested as well. For the guardians who bring their children for testing mostly it will be after their biological parents had passed away and they suspect that the death cause was HIV. Some guardians do it with the need to help while some do it as a means of trying to stigmatise the child. If the child is tested positive they might withdraw the guardianship with fear that they might also contract HIV or that they think that the child has no future hence they are wasting their own resources.

It was also noted that service providers do not track the history of the parents who test HIV positive. Thus when someone come for testing their children's history is not taken. Thus the chances of knowing whether these parents who got tested have other children who can be exposed is left out.

From the youth centres it was also noted that the uptake of HIV testing and counselling among the minors is low. This is attributed to the fact that the Information, education and communication materials which are developed do not target the children. The messages which are disseminated through the mass media targets mostly the adults. The issues to do with HIV are related with the sexual behaviours which the society feels it is not supposed to involve the children.

5.2 Summary of the Study

The study was an Assessment of HIV testing and counselling services uptake (case of minors) in Mutare district, Zimbabwe. A sample of 70 respondents was selected using the convenience sampling method in Mutare urban district. The study participants constituted parents/guardians who are the care givers of children who are under the age of sixteen years of age who need parent's consent in decision making and children under the age of 16. Interviews and questionnaires were administered to these respondents respectively. The data was presented using tables and graphs.

The major barriers to HIV testing and counselling uptake were related to fear and stigma and discrimination. Parents/guardians reported that they were willing to have their children tested for HIV but showed that they had negative attitudes towards testing since they reported that they were not willing to have their children tested when they were looking healthy. Out of a total number of 44 children who responded, only 4 (9.1%) were tested. Adding on to that stigma and discrimination which has continued to prevail in this world of HIV and AIDS was cited as another hindering factor where people feared what the society would say after taking their children for testing or being seen visiting the clinic to access ARVs for their children hence individuals would not take their children to the clinic to avoid labels and to maintain the social identity. Though the guardians believed that children should be tested they still believe that disclosing the HIV's status to children it will be determined by the child' age since young children cannot keep their status as confidential as they want it to be in the society.

The study revealed that HIV information is being disseminated as all the respondents stated that they have heard about HIV and AIDS before and they know where to get the services. This calls for a massive awareness campaign in the community in order for children to get tested and to counter fear on the parent/guardians on HIV testing for children. Furthermore, children are not getting information about HIV testing when they visit the health centres but concentrated on encouraging adults to get tested. There is also

weak referral system for those parents who visit the health centres for testing and counselling services.

All the respondents showed that they had knowledge on how HIV and AIDS are transmitted. However, much of the respondents' knowledge of HIV transmission was centred on adults and not children. For example, 90% of the respondents said HIV is transmitted in adults through sex with an infected partner/s and less than half of the respondents (45%) said transmission in children is through mother to child during pregnancy, at birth and during breastfeeding.

The results of the study showed that all the respondents were against the idea that illness was caused by witchcraft since they will seek treatment from the clinics as compared to traditional and faith healers. The study concludes that the attitudes of parents/guardians were highly positive when it comes to the causes of illness among children and source of treatment.

5.3 Recommendations

Given the fact that the purpose of this study was to assess the uptake of HIV and AIDS testing and counseling among the minors, the following recommendations can be made basing on the findings from data analysis. The table below summarizes the

recommendations which can increase the uptake of HIV testing and counseling among minors.

Table 5: Recommendations

Activity	**Target group**	**Responsible Authority**	**Time frame**
Awareness campaigns on HIV testing and counselling	School children Churches Communities	Ministry of health New start centre	December 2014
Making HIV and AIDS an examinable subject in schools	School children	Ministry of education	June 2014
Putting referral systems for the parents who comes for HIV testing	Parents	Health centres New start centre	June 2014
Conduct a follow up research on stigma index	People living with HIV and AIDS	Zimbabwe National Network for People living with HIV and AIDS	December 2014

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Appendix A: Permission Letter

AFRICA UNIVERSITY
(A United Methodist - Related Institution)

INSTITUTE OF PEACE LEADERSHIP AND GOVERNANCE

P.O. BOX 1320, MUTARE, ZIMBABWE - TEL.: (263-20) 66788/60075/60026/61611 - FAX: (263-20) 66788/61785 - E-MAIL: iplgsec@africau.ac.zw

5 April 2013

TO WHOM IT MAY CONCERN

Re: Permission to Undertake Research for Dissertation at Africa University

Philda Jani student registration number **118190** is a student at Africa University. She is enrolled in a degree program in Public Policy and Governance and is currently conducting research for her project, which is required for completion of the program in June 2013. The research topic is **"HIV/AIDS and Public Policy – Testing and Counselling".** Philda is expected to undertake this research during the period January- April 2013 before the dissertation can be submitted to the Faculty in May 2013.

The student will share with you the results of this research after its approval by the Institute.

We thank you for your support and cooperation regarding this research.

Yours sincerely

Dr. P. Machakanja
Director

Appendix B: Interview guide: Parents/guardians

INTERVIEW GUIDE: Parents/guardians

I am Phillda Jani, a student with the Africa University. I am carrying out a research on assessment of the uptake of HIV testing and counseling (HTC) services case of minors in Mutare district, Zimbabwe. This research is for academic purposes only and your contribution will be treated with high confidentiality. Your cooperation will be highly appreciated.

1. Male◯ Female◯ Age ◯

2. What highest academic level did you attain?

3. Are you the biological parent of children in your custody?

4. Do you have any information regarding HTC?

5. Do you know where HTC sites are?

6. Have you ever been tested for HIV and AIDS?

7. Have you disclosed your HIV status to your children?

8. Have you ever send your child for testing?

9. Why do you think some parents do not take their children for HIV test?

10. Which age do you think is right or children to talk about HIV?

11. Do you discuss the issues of HIV and AIDS with your children?

12. Do you think it is important for pregnant mothers to go for PMTCT?

13. What is it that can hinder minors from accessing the HTC?

14. Do the staff members at the clinic talk to you about testing and treatment for children at any given time during your pregnancy?

15. Do you know how HIV and AIDS can be transmitted? Name the forms of HIV transmission you know.

16. Is it possible for a healthy looking child to have HIV?

17. Do you think it is important to know your child's HIV status?

18. What is it that comes into your mind when your child gets ill?

19. Do you believe an HIV positive person, be it a child or an adult can live for a longer period of time after getting ART?

20. Suppose your child gets ill, where do you go to seek treatment first?

21. Are children able to manage their HIV status?

22. Do you think minors are sexually active?

23. Is stigma and discrimination still existent in your community?

24. What will be your reaction if your child asks for your consent to go for HIV test?

25. If your children are on treatment would you let them know that they are taking ARVs and for what reasons?

26. What can be done to increase the uptake of HIV services among the minors?

Appendix C: Questionnaire: Children

QUESTIONAIRE: CHILDREN

I am Phillda Jani, a student with the Africa University. I am carrying out a research on the assessment of the uptake of HIV testing and counseling (HTC) services case of minors in Mutare district, Zimbabwe. This research is for academic purposes only and your contribution will be treated with high confidentiality. Your cooperation will be highly appreciated.

1. Male ☐ Female ☐ Age ☐

2. Who do you stay with? Parent ☐ Guardian ☐

3. Do you have any information regarding HTC? Yes ☐ No ☐

4. Do you know where HTC sites are? Yes ☐ No ☐

5. Have you ever been tested for HIV and AIDS? Yes ☐ No ☐

6. If yes did you get consent from your parents or guardian? Yes ☐ No ☐

7. Do you know your parent or guardian's status? Yes ☐ No ☐

8. Why do you think some parents do not take their children for HIV test? Cost ☐

Fear ☐ Lack of knowledge ☐ Stigma and discrimination ☐

9. Which age do you think is right for children to talk about HIV? <5 ☐ 5 -10 ☐

10-16 ☐ 16+ ☐

10. Do you discuss the issues of HIV and AIDS with your parents or guardians? Yes ☐

No ☐

11. Do you think it is important for pregnant mothers to go PMTCT? Yes ☐ No ☐

12. What is it that can hinder minors from accessing the HTC? Cost ☐ Fear ☐ Lack of knowledge ☐

13. Do the staff members at the clinic talk to you about HTC? Yes ☐ No ☐

14. Is it possible for a healthy looking child to have HIV? Yes ☐ No ☐

15. Do you believe an HIV positive person, be it a child or an adult can live for a longer period of time after getting ART? Yes ☐ No ☐

16. Suppose you get ill, where do you go to seek treatment first? Clinic ☐ Prophet ☐ Traditional healers ☐

17. Do you think minors should know their HIV status? Yes ☐ No ☐

17. Do you think you are able to manage your HIV status? Yes ☐ No ☐

18. Do you think children are sexually active? Yes ☐ No ☐

19. Is stigma and discrimination still existent in your community? Yes ☐ No ☐

20. What can be done to increase the uptake of HIV services among children the under 16 years?